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No. 89-450

In the Supreme Court of the United States

OCTOBER TERM, 1989

TEXAS MEDICAL ASSOCIATION, ET AL., PETITIONERS

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED

Whether the district court had jurisdiction over petitioners' claims concerning the amount of reimbursement under Part B of the Medicare Act for services rendered prior to January 1, 1987, the effective date of statutory amendments permitting judicial review of certain benefit amount determinations under Part B.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	8
Conclusion	15

TABLE OF AUTHORITIES

Cases:

Anderson v. *Bowen*, 881 F.2d 1 (2d Cir. 1989) .. 11
Association of Seat Lift Mfrs. v. *Bowen*, 858 F.2d 308 (6th Cir. 1988), cert. denied, 109 S. Ct. 1528 (1989) 9, 10, 11
Bowen v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986) 2, 3, 8, 12
Insurance Corp. of Ireland, Ltd. v. *Compagnie des Bauxites de Guinee*, 456 U.S. 694 (1982) 13, 14
Kuritzky v. *Blue Shield of Western New York, Inc.*, 850 F.2d 126 (2d Cir. 1988), cert. denied, 109 S. Ct. 787 (1989) 7, 11
Linoz v. *Heckler*, 800 F.2d 871 (9th Cir. 1986) ... 11
Mansfield, C.& L.M.R.R. v. *Swan*, 111 U.S. 379 (1884) 14
McCuin v. *Secretary of Health & Human Services*, 817 F.2d 161 (1st Cir. 1987) 11, 12
Medical Fund-Philadelphia Geriatric Center v. *Heckler*, 804 F.2d 33 (3d Cir. 1986) 11
United States v. *Erika, Inc.*, 456 U.S. 201 (1982) .. 2, 3, 8

Statutes and regulations:

Medicare Act, 42 U.S.C. 1395 *et seq.*:
Pt. A:
42 U.S.C. 1395ff 6, 8, 13

Statutes and regulations—Continued: Page

42 U.S.C. 1395ff(b) (Supp. III 1987) 3
42 U.S.C. 1395ff(b)(1) (1982 & Supp. V 1987) 12
42 U.S.C. 1395ff(b)(2) (1982 & Supp. V 1987) 12
Pt. B:
42 U.S.C. 1395j-1395w (1982 & Supp. V 1987) 2
42 U.S.C. 1395k (1982 & Supp. V 1987) 2
42 U.S.C. 1395u(a)(1) 2
42 U.S.C. 1395u(b)(3) (1982 & Supp. V 1987) 2, 4
42 U.S.C. 1395u(b)(3)(C) (1982 & Supp. V 1987) 3
Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, Tit. IX, 100 Stat. 1874:
§ 9341(a), 100 Stat. 2037 3
§ 9341(b), 100 Stat. 2038 3
20 C.F.R. 404.989 10
42 C.F.R.:
Sections 405.501 *et seq.* 2
Section 405.502 4
Section 405.502(a)(1) 2
Section 401.502(a)(2) 2
Section 401.502(a)(7) 2
Section 405.841(b) 10
Section 405.841 .... 2, 6
Miscellaneous:
Medicare Carrier Manual 2, 4

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BRIEF FOR THE FEDERAL RESPONDENT ~~SERVICES~~ IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-100a) is reported at 875 F.2d 1160. The order of the district court (Pet. App. 106a-107a) is reported at 678 F. Supp. 643, and the findings of fact and conclusions of law of the district court (Pet. App. 108a-121a) are reported at 678 F. Supp. 643.

JURISDICTION

The judgment of the court of appeals was entered on June 27, 1989, and a petition for rehearing was denied on July 27, 1989 (Pet. App. 122a). The petition for a writ of certiorari was filed on September 14, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Medicare Part B is a voluntary supplemental insurance program that provides reimbursement for certain physician and related ancillary services. 42 U.S.C. 1395k (1982 & Supp. V 1987). Part B covers, in general, 80% of the "reasonable charges" of physicians' services and various related health services. 42 U.S.C. 1395j-1395w (1982 & Supp. V 1987). The determination of the rates and amount of benefits under Part B and the payment of benefits due is undertaken by private insurance carriers pursuant to contracts with the Secretary of Health and Human Services. 42 U.S.C. 1395u(a)(1); *United States* v. *Erika, Inc.*, 456 U.S. 201, 202-204 (1982); *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667, 674-675 (1986).

The carrier sets the "reasonable charge" for covered services according to flexible guidelines set forth in the Medicare Act, implementing regulations and the Carrier's Manual. 42 U.S.C. 1395u(b)(3) (1982 & Supp. V 1987); 42 C.F.R. 405.501 *et seq.*; *Medicare Carrier Manual* §§ 5000 *et seq.* The "reasonable charge" for a service is the lowest of: (1) a physician's actual charge for the service; (2) the physician's "customary charge" for similar services as determined by the physician's fee profile developed by the carrier; or (3) the "prevailing charge recognized by the carrier" for similar services in the locality. 42 U.S.C 1395u(b)(3) (1982 & Supp. V 1987); 42 C.F.R. 405.502(a)(1) and (2). The carrier is also authorized to consider "[o]ther factors that may be found necessary and appropriate with respect to a category of service to use in judging whether the charge is inherently reasonable." 42 C.F.R. 402.502(a)(7). Pet. App. 2a-3a. Governing regulations also provide that after a claim is decided and paid, it may be reopened for any reason within one year and for "good cause" within four years. 42 C.F.R. 405.841.

The statute provides for "a fair hearing by the carrier" if a dispute arises over the amount of benefits due.

42 U.S.C. 1395u(b)(3)(C) (1982 & Supp. V 1987). During the time period relevant to this dispute, however, the Act did not provide for administrative review by the Secretary or judicial review of the carrier's final determination, after a hearing, of the "reasonable charge" for covered services. By contrast, the Act did provide for administrative review by the Secretary and judicial review of disputes concerning an individual's entitlement to participate in the Medicare program and the amount of benefits under Part A (which covers hospital and related services) if the amount in controversy exceeded $100 for administrative review and $1000 for judicial review. 42 U.S.C. 1395ff(b) (1982 & Supp. V 1987). In view of the Act's carefully drawn provisions, the Court held in *Erika* that the Act precludes judicial review of the carrier's determination of the amount of benefits payable under Part B. 456 U.S. at 206-211.[1] In 1986, Congress amended Section 1395ff(b) to permit judicial review of Part B benefit amount determinations where the amount in controversy is $1000 or more. Omnibus Budget Reconciliation Act of 1986, Tit. IX, Pub. L. No. 99-509, § 9341(a), 100 Stat. 2037-2038. However, those amendments apply only to services furnished on or after January 1, 1987. § 9341(b), 100 Stat. 2038. Because the services at issue in this case were rendered prior to that date, the 1986 amendments are inapplicable here.

2. Respondent Blue Cross and Blue Shield of Texas (BCBST) is a private insurance carrier that contracted with the Health Care Financing Administration (HCFA) to administer the Medicare Part B program in Texas. Prior to July 1985, BCBST had used local numerical codes to identify medical procedures and services for purposes of determining a physician's "customary charge" or the local

[1] In *Michigan Academy*, the Court held that the preclusion of review recognized in *Erika* did not apply to challenges to the methodology prescribed by the Secretary to be used by the carriers in determining the reasonable charge for covered services. 476 U.S. at 674-678.

"prevailing charge," which in turn limits the "reasonable charge" for services under Part B. However, in July 1985, BCBST was required by HCFA to convert to a new nationwide coding system, the HCFA Common Procedure Coding System (HCPCS). The conversion required that BCBST transfer data for its own four-digit codes to new five-digit HCPCS codes. In light of a statutory freeze on customary and prevailing charge levels then in effect (see Pet. App. 4a n.1), the HCPCS conversion could neither increase nor decrease the amounts paid for any medical service or procedure. *Id.* at 3a-4a.

BCBST converted customary and prevailing charge data to the new HCPCS codes for all but 18 medical procedures. Although BCBST was in possession of the data necessary to convert the remaining 18 codes, those data were not immediately retrievable from the BCBST computer system. In response to physician complaints about underpayments for those procedures, BCBST, without HCFA's knowledge or approval, set the fees for each of the 18 HCPCS codes at the highest prevailing rate in the State. As a result, between July 1985 and April 1986, BCBST payments for procedures covered by the 18 codes did not reflect valid customary and prevailing charge data, as required by the Act (Section 1395u(b)(3)), implementing regulations (42 C.F.R. 405.502), and the *Medicare Carrier Manual* (§ 5020). Pet. App. 4a.

HCFA learned in October or November 1985 that physician payments on certain codes exceeded the amount paid before the conversion to HCPCS codes. Pet. App. 5a. HCFA therefore conducted a review in December 1985 and discovered that the overpayments were attributable to the 18 procedure codes for which BCBST was using the highest rate in the State. By letter dated January 22, 1986, HCFA informed BCBST that the pricing for the 18 codes was incorrect and that it should reinstate valid customary and prevailing data in use prior to the conversion to the new codes.

See Pet. App. 26a-27a. By April 1, 1986, the BCBST computers had matched the customary and prevailing charge data with the 18 new procedure codes, and BCBST accordingly replaced its prior statewide fees with reasonable charges calculated on the basis of the newly retrieved data. *Id.* at 5a-6a.

HCFA initially decided to forgo any efforts to recover overpayments made while the higher rates were in effect between July 1985 and April 1986, based on BCBST's estimate that the costs involved would be greater than the overpayments. Pet. App. 4a. BCBST subsequently determined that the recovery cost would not be as great as first estimated and that the overpayments totalled several million dollars. HCFA then requested BCBST to reprocess approximately 440,000 claims using appropriate customary and prevailing charge data. The reprocessing revealed overpayments totalling $13.3 million (excluding overpayments of less than $50), which were made to 5,125 physicians and almost 15,000 beneficiaries. HCFA consequently directed the carrier to institute a program to recover the overpayments. Pet. App. 6a-7a.[2]

3. On October 16, 1987, petitioners, a group of physicians and Medicare Part B beneficiaries in Texas, filed this suit for injunctive relief barring recovery of the overpayments. Pet. App. 8a.[3] The district court entered a

[2] BCBST sent letters in August 1987 to the affected physicians and beneficiaries requesting repayment of the overpayments and affording them the option of paying in either a lump sum or installments. Beneficiaries were further advised that they could apply for a waiver of liability if they were without fault in causing the overpayment and repayment would create a financial hardship. Both physicians and beneficiaries also were informed of their right to an administrative hearing to contest the determination that an overpayment had been made. Pet. App. 7a-8a.

[3] Petitioners sought to represent classes of physicians and beneficiaries, but the district court has not certified a class. Pet. App. 8a n.11.

preliminary injunction barring the recovery. Pet. App. 106a-121a. In determining that it had jurisdiction to issue a preliminary injunction, the district court stated that "[t]his dispute centers upon whether the statewide fee schedule was a proper or improper payment methodology. As such, this Court has jurisdiction according to *Michigan Academy*." *Id.* at 112a. The court next held that exhaustion of administrative remedies by petitioners was "an unnecessary predicate" to the court's exercise of jurisdiction because, in its view, BCBST's hearing officers would be bound by the Secretary's interpretation that the statewide fee was improper and could not provide petitioners the relief they sought. *Id.* at 115a. In assessing petitioners' likelihood of success on the merits—an essential prerequisite to the issuance of a preliminary injunction—the district court did not address the merits of BCBST's failure to use customary and prevailing charge data during the relevant period; it instead concluded that BCBST would not be authorized to reopen the prior payment determinations because, in the court's view, there was no "good cause" for doing so within the meaning of the applicable regulation (42 C.F.R. 405.841). Pet. App. 116a-118a.

4. The court of appeals reversed (Pet. App. 1a-25a). It concluded that 42 U.S.C. 1395ff, as applied to claims for services rendered prior to the January 1, 1987, effective date of the amendment authorizing judicial review in certain circumstances, precludes judicial review of petitioners' challenge to BCBST's proposed recovery of overpayments. The court of appeals accordingly vacated the preliminary injunction and remanded the case to the district court to dismiss for lack of subject matter jurisdiction. Pet. App. 2a.

The court of appeals explained that under *Michigan Academy*, the determinative issue concerning a court's jurisdiction to hear a Part B challenge is "whether the challenge is to the validity of a rule, regulation, or instruc-

tion of the Secretary or merely a claim that [the carrier] 'misapplied or misinterpreted valid rules and regulations.' " Pet. App. 13a, (quoting *Kuritzky* v. *Blue Shield of Western New York, Inc.*, 850 F.2d 126, 128 (2d Cir. 1988), cert. denied, 109 S. Ct. 787 (1989)). In this case, the court stated, it was called upon to assess whether a carrier hearing officer has the ability—"free of binding regulations and determinations of the Secretary and subordinates" (Pet. App. 14a)—to hear and decide petitioners' complaints deriving from BCBST's "(i) replacement of the set statewide fees for the 18 codes with fee profiles which reflect valid customary and prevailing charge data, and (ii) effort to recoup overpayments made to physicians and patients while set statewide fees were used since the customary and prevailing charge data could not be retrieved by BCBST's computers." *Ibid.*

On the first issue, the court rejected petitioners' claim that the HCFA directions regarding the appropriate use of set statewide fees constituted regulations or instructions that would direct the outcome of a hearing officer's decision. Pet. App. 14a-18a. It explained that when "read in the context of the relevant statutes, regulations and the BCBST contract with HCFA, these instructions merely advise BCBST to obey the law by applying available valid customary and prevailing data to the new HCPCS codes." *Id.* at 16a. The court also found unpersuasive petitioners' contention that jurisdiction was available to review the carrier's decision to reopen the claims. *Id.* at 18a-22a. In its view, the question "whether good cause existed [for reopening the claims] is a matter for independent determination by the [hearing officer], and thus is a matter insulated by 42 U.S.C. § 1395ff from judicial review as so plainly declared in *Michigan Academy* and its progeny." *Id.* at 22a.

ARGUMENT

The fact-bound decision of the court of appeals correctly applies this Court's jurisdictional rulings in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), and *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), and does not conflict with any decision of another court of appeals. Especially in light of Congress's intervening amendment of 42 U.S.C. 1395ff to permit judicial review of benefit amount determinations under Part B of the Medicare program, the jurisdictional holding below presents no issue of continuing importance warranting reivew by this Court.

1. a. In *Erika*, the Court held that 42 U.S.C. 1395ff precludes judicial review of Part B reimbursement determinations. *Michigan Academy* carves out an exception to that preclusion: judicial review is available where the plaintiff challenges the methods prescribed by the Secretary's regulations and instructions for calculation of Part B benefits, because such prescriptions bind the carrier hearing officer and therefore could not be considered in a carrier hearing. *Michigan Academy*, 476 U.S. at 675-678. The court of appeals applied these principles to the particular circumstances of this case, expressly following a number of decisions of other courts of appeals, including several upon which petitioners rely. See Pet. App. 13a-14a & n.19, 17a & n.24.

After a careful review of the record, the court of appeals concluded that the HCFA letters and memoranda cited by petitioners "are not regulations or 'instructions' which would bind a [hearing officer] to find the use of the set statewide fee to compute the disputed payments to the physicians and patients were *per se* illegal" (Pet. App. 18a). The court found that those materials amounted to generalized advice and directions to follow governing law and regulations, which require the reasonable charge to be based on customary

and prevailing charge data, where available. That advice was rendered in HCFA's auditing and oversight role, under which HCFA " 'assur[es] that Carriers apply pertinent statutes, regulations, and instructions in making such [reasonable charge] determinations, and br[ings] pertinent information to the Carrier's attention for use in carrying out these responsibilities.' " *Id.* at 16a-17a, (quoting *Association of Seat Lift Mfrs.* v. *Bowen*, 858 F.2d 308, 315 (6th Cir. 1988), cert. denied, 109 S. Ct. 1528 (1989)). The court observed in this regard that "HCFA limited its directions and advice to a discussion of proper handling of the conversion project and the generalities of setting fees. HCFA did not purport to determine reasonable charges for the carrier, nor did HCFA tell BCBST that after properly crosswalking or loading the valid customary and prevailing data that it could not opt to set a statewide fee for a given procedure code." Pet. App. 17a n.24.

Petitioners cannot object to correspondence by HCFA that simply instructs carriers to follow governing law, while leaving application of the law to the carrier, and it clearly is within the discretion of a carrier (and therefore of its hearing officers) to reopen claims, where reopening is otherwise permissible, to correct legal errors. Indeed, BCBST candidly acknowledges (Br. in Opp. 4-7) that its prior benefit amount determinations were inconsistent with the Act and governing regulations and agrees (Br. in Opp. 7-8) that it was not issued blanket instructions to reopen all claims, regardless of whether the conditions for reopening existed. This therefore is not a case in which HCFA forced a particular interpretation of the Act or regulations on an unwilling carrier. Because petitioners' contention therefore is, at bottom, a challenge to BCBST's initial redetermination of the amount of benefits payable on their individual claims, rather than a challenge to any method *prescribed* by the Secretary for setting or redetermining reasonable charges for the 18

procedure codes, it falls within *Erika*'s preclusion of judicial review, rather than *Michigan Academy*'s exception. For this reason, the court of appeals correctly held that judicial review is foreclosed.[4]

The court of appeals also correctly held that the district court lacked jurisdiction to review the carrier's proposal to recover overpayments made pursuant to benefit amount determinations under the statewide fees. See Pet. App. 18a-22a. Although BCBST informed beneficiaries and physicians of its initial determination that the prior determinations were erroneous and that an overpayment had been made, it also informed beneficiaries and physicians of their right to challenge that new determination in a hearing before the carrier hearing officer. At such a hearing, beneficiaries and physicians would be free to argue that the prior determinations should not be reopened because there was no "good cause" for doing so, as required by governing regulations. 42 C.F.R. 405.841(b); 20 C.F.R. 404.989. As the court explained, "[n]othing in the trial court's detailed analysis discusses or describes an 'instruction' of HCFA or the Secretary which would command a [carrier hearing officer] to reject a claim or defense by a physician or patient that BCBST lacked good cause to reopen the payment determinations." Pet. App. 20a-21a. And when the court of appeals afforded petitioners a further opportunity to submit any such instruction or directive that had been disclosed in

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[4] Petitioners' apparent attempt (Pet. 13) to distinguish between payment determinations involving small amounts and those fixing the level of reimbursement for a class of claims is unavailing. Although Congress anticipated that Part B determinations generally would involve small claims, Congress "in fact precluded review of *all* Part B payment determinations prior to January 1, 1987, rather than only those specific determinations judged on a case-by-case basis to be 'minor' or 'trivial.' " *Association of Seat Lift Mfrs.*, 858 F.2d at 316.

discovery, they were unable to do so. *Id.* at 19a n.25, 21a n.29; see note 6, *infra*.[5]

b. The other court of appeals decisions cited by petitioners (Pet 15-17) apply *Michigan Academy* and *Erika* in a manner consistent with the court of appeals' ruling in this case. The Second and Sixth Circuits, in finding judicial review of particular Part B disputes barred, have recognized that *Erika*, rather than *Michigan Academy*, controls the question whether federal courts have jurisdiction over challenges to a carrier's Part B reimbursement determination. *Anderson* v. *Bowen*, 881 F.2d 1, 3-4 (2d Cir. 1989); *Association of Seat Lift Mfrs.*, *supra*; *Kuritzky* v. *Blue Shield of Western New York, Inc.*, 850 F.2d 126, 128 (2d Cir. 1988), cert. denied, 109 S. Ct. 787 (1989). See also *Medical Fund-Philadelphia Geriatric Center* v. *Heckler*, 804 F.2d 33, 36-39 (3d Cir. 1986); *Linoz* v. *Heckler*, 800 F.2d 871, 875-876 (9th Cir. 1986).

In *McCuin* v. *Secretary of Health & Human Services*, 817 F.2d 161 (1st Cir. 1987), the claimant raised a due process objection to the Secretary's application of regulations

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[5] Petitioners contend (Pet. 11, 16, 19) that recent revisions of the Carriers Manual provisions concerning when a physician may be found to be without fault for purposes of defeating recovery of overpayments indicates that HCFA has "taken this matter out of the carrier's hands" (Pet. 19). The revisions, which are reproduced at Pet. App. 137a-140a, state that a physician is responsible for knowing the reasonable charge for his services. *Id.* at 140a. Prior provisions of the Carriers Manual provided that a physician would not be liable if the physician had no reason to question the amount of an increase in his reasonable charge screen or if he promptly brought the matter to the carrier's attention. *Id.* at 137a. We have been informed by HHS that the issuance of these revisions, which are of general applicability, was unrelated to this case. On October 2, 1989, the court of appeals denied petitioners' application for leave to file a motion for reconsideration in light of these revisions (see Pet. 11), and there is no occasion for this Court to consider petitioners' efforts to intrude them into the case here.

governing the Appeals Council's reopening of Medicare Part A claims that were subject to review within HHS. Although the amount of the reopened claim was below the $1000 jurisdictional amount required for judicial review of Part A claims (see 42 U.S.C. 1395ff(b)(1) and (2) (1982 & Supp. V 1987)), the court held that judicial review was available because the case presented the type of " 'substantial statutory and constitutional challenge[ ] to the Secretary's administration' " of the Act that this Court held reviewable in *Michigan Academy*. *McCuin*, 817 F.2d at 165, quoting *Michigan Academy*, 476 U.S. at 680. The court then construed the regulation not to permit the Appeals Council to reopen the claim in the circumstances presented. 817 F.2d at 167-175. *McCuin* is in some tension with the principle that jurisdiction does not lie in cases involving the application of the Secretary's regulations to individual claims. However, the *McCuin* court found jurisdiction "particularly appropriate" in view of the constitutional challenge to the Secretary's enforcement of the statute. 817 F.2d at 165. The present case involves no claim of a constitutional violation. Furthermore, the court stressed in *McCuin* that the plaintiffs challenged only the Appeals Council's reopening authority, which is essentially a collateral issue, not matters going to the merits of the payment determination. Here, petitioners do challenge the merits of the payment redeterminations, as well as the carrier's reopening authority. Finally, *McCuin* arose under Part A, not Part B, and it involved action by the Secretary himself (through the Appeals Council), not, as here, the actions of a private insurance carrier administering the Medicare program under contract with the Secretary. *Michigan Academy* explains that the preclusion of review under Part B applies principally to actions of the carrier.

In sum, the court of appeals adhered to the jurisdictional principles announced by this Court in *Erika* and *Michigan Academy* and followed by other courts of appeals since

those decisions. Petitioners simply disagree with the court of appeals' application of those principles to the atypical circumstances of this case. That fact-bound conclusion does not warrant further review by this Court. Nor are petitioners substantially prejudiced by the ruling below, because it leaves them free to raise their objections before BCBST's hearing officers.

c. In any event, the jurisdictional issue concerning the precise dividing line between claims that are precluded by *Erika* and those that are allowed by *Michigan Academy* is of little continuing importance, since Congress has amended 42 U.S.C. 1395ff to permit judicial review of benefit amount determinations under Part B (including the validity or application of regulations and instructions issued by the Secretary) where the aggregate amount in controversy is $1000 or more. This new provision should ensure that significant legal issues arising in the Part B program will be heard by the courts in the future. At the same time, this amendment underscores Congress's intention to preclude review where the amount-in-controversy requirement is not satisfied.

2. Petitioners also argue (Pet. 20-25) that the court of appeals erred in not deferring to the district court's determination that it had jurisdiction to review their claims. This contention is meritless. It is axiomatic that federal courts are courts of limited jurisdiction. As this Court explained in *Insurance Corp. of Ireland, Ltd.* v. *Compagnie des Bauxites de Guinee*, 456 U.S. 694, 702 (1982), "[s]ubject-matter jurisdiction * * * is an Art. III as well as a statutory requirement; it functions as a restriction on federal power, and contributes to the characterization of the federal sovereign." One of the legal consequences flowing from this rule requires a federal court, on its own motion if necessary, " 'to deny its jurisdiction, and, in the exercise of its appellate power, that of all other courts of the United States, in all

cases where such jurisdiction does not affirmatively appear in the record.' " *Ibid.* (quoting *Mansfield, C.& L.M.R.R.* v. *Swan*, 111 U.S. 379, 382 (1884)). Because jurisdiction did not "affirmatively appear in the record" in this case, the court of appeals correctly held that the district court was without jurisdiction.[6]

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[6] Nor is review by this Court necessary to address petitioners' claim (Pet. 22-23) that the court of appeals erroneously considered "post-injunction" evidence on the question whether the agency's advisory memoranda constituted binding instructions. Petitioners represented at oral argument before the court of appeals that documents had subsequently been produced in the course of proceedings in the district court concerning the possible issuance of a permanent injunction, which allegedly proved that HCFA mandated that BCBST reopen the claims. Pet. App. 19a n.25. Based on this representation, the court requested the parties to submit any such documents, reserving judgment on whether documents not specifically a part of the record compiled at the time of the issuance of the preliminary injunction, but since made a part of the record before the district court, could be considered by an appellate court in reviewing a preliminary injunction. Because the court of appeals' review of those documents led it to conclude that the documentation failed to sustain jurisdiction, the court stated that "in effect we have simply not used non-record material." *Ibid.* In any event, petitioners do not explain how they were prejudiced by the court's request for further documentation. If anything, contrary to petitioners' assertions (Pet. 22), they were given more than ample opportunity to furnish documents containing binding instructions that could be challenged in this suit.

CONCLUSION

The petition for a writ of certiorari should be denied.
Respectfully submitted.

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